Health Services
LOS ANGELES COUNTY

Expected Practices

Specialty: Rheumatology

Subject: Rheumatoid Arthritis (RA)

Date: June 23, 2014

Purpose: Approach to the diagnosis and initial management of Rheumatoid Arthritis (RA)

Target Audience: Primary Care Providers

Expected Practice:

When to think of RA

RA is a symmetric inflammatory polyarthritis affecting primarily small joints. Small hand joints (primarily MCPs and PIPs), wrists, foot joints (MTPs and PIPs) and ankles are commonly affected early in the course. DIPs are not usually affected.

RA does not affect axial skeleton early in its course. If it does, it will do so late in the course and will only affect the cervical spine. Thus, low back pain, should not trigger a work-up of RA.

Usually, patients with RA do not have extra-articular complaints at presentation. Concomitant reports of photosensitive rashes, oronasal ulcerations, hair loss, kidney problems, thromboembolic disease, pregnancy morbidity make SLE a much more likely diagnosis.

RA affects primarily joint synovium (arthritis). Though tendon involvement and tenosynovitis may be seen, they are not prominent features, and will only be seen in the presence of significant joint involvement. Therefore, conditions presenting preferentially with tenosynovitis should not trigger a work-up for RA. Instead, and based on clinical context, crystalline diseases such as gout, infections such as Neisseria gonorrhea, and spondyloarthropathies such as psoriatic, reactive, enteropathic arthritis, or ankylosing spondylitis, should be preferentially entertained.

Arm stiffness and fatigue although common in RA, are always associated with presence of swollen and tender joints. Fatigue in and of itself should not trigger work-up for RA.The typical patient is a female of reproductive age, smoker, with a family history of RA or other autoimmune disease. Prompt diagnosis

This *Expected Practice* was developed by a DHS Specialty-Primary Care Work Group to fulfill the DHS mission to ensure access to high-quality, patient-centered, and cost-effective health care. SPC Work Groups, composed of specialist and primary care provider representatives from across LA County DHS, are guided by 1) real-life practice conditions at our facilities, 2) available clinical evidence, and 3) the principle that we must provide equitable care for the entire population that LA County DHS is responsible for, not just those that appear in front of us. It is recognized that in individual situations a provider's clinical judgment may vary from this *Expected Practice*, but in such cases compelling documentation for the exception should be provided in the medical record.

and early treatment are important for achievement of remission, prevention of radiographic damage, and avoidance of extra-articular complications such as cardiovascular disease and lymphoma.

How to test and risk stratify for RA

The patient should have at least one demonstrable swollen joint. If this is the case, then follow the risk stratification algorithm below.

Testing for rheumatoid factor (RF), anti-cyclic citrullinated peptide antibodies (a-CCP), ESR or CRP is important. In the absence of collateral symptoms as above, extensive serological testing with other specificities (ANA, a-dsDNA, complements) is not necessary or indicated.

ACR/EULAR 2010 RA Classification Criteria

- **Swelling in at least 1 joint AND**
- **Synovitis not otherwise explained by another disease**
- **Threshold for diagnosis of RA ≥6**

	Score (0-10)
JOINTS	
=1	0
2-10 large	1
1-3 small	2
4-10 small	3
>10 (≥1 small)	5
SEROLOGY	
Negative	0
Low positive	2
High positive	3
DURATION	
<6 weeks	0
≥6 weeks	1
ACUTE PHASE	
Normal	0
Abnormal	1

Aletaha D, et al. Arthritis Rheum. 2010;62:2569-2581

Initial management of newly diagnosed RA by the PCP: All new diagnoses of RA should be referred to rheumatology via eConsult. If beginning therapy while awaiting Rheumatology care, considerations for medical treatment of patients with RA are noted below.

- **Steroids** have limited and restricted use in early RA. They may be used as bridging strategies until disease modifying anti-rheumatic agents (DMARDs) are initiated and dose optimized. Their use in pure articular disease in doses over 10 mg increases overall mortality. Singular IM Depomedrol injections at 1 mg/kg at diagnosis, or daily doses of ≤10 mg are acceptable with rapid down-titration once doses and numbers of DMARDs are optimized and disease activity decreases.

- **Methotrexate** (MTX) is the main preferred DMARD for treatment and can be started by the PCP. Prior to initiation, a creatinine needs to be checked since it is eliminated by the kidney, and therefore contraindicated in acute kidney injury and/or CKD, depending on stage. LFTs, acute and chronic hepatitis B/C panels as well as CXR need to be obtained, as it is contraindicated in virally infected individuals (without a liver biopsy), or in subjects with underlying interstitial lung disease. The rheumatologist will suggest alternatives in those cases until the patient establishes subspecialty follow-up. MTX is generally started at 7.5 mg qweek x 2 weeks with quick up-titration to 15mg qweek and then 20-25 mg qweek after that based on tolerance and with interim follow-up of LFT and CBC prior to each dose escalation. Once on a stable dose of MTX, these labs can be monitored 4-6 times per year.